KootenaiHealth

CONDITIONS OF ADMISSION TO KOOTENAI HEALTH

I, THE UNDERSIGNED, HEREBY CONSENT (AGREE) TO RECEIVE MEDICAL CARE FROM THE PRACTITIONER(S) RESPONSIBLE FOR MY DIAGNOSIS AND TREATMENT. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I may ask questions about my medical care and make my wishes known to my practitioners and/or staff. I will participate in my care and foster a safe environment for myself, staff, and other patients within Kootenai Health (KH). I understand that my care is under the direction of my attending physicians, who may be independent contractors and not employees or agents of KH. KH is not liable for the acts or omissions of such independent contractors. I acknowledge that KH is a teaching hospital and that teachers, trainees, residents and students may observe or participate in my care. I understand that photographs and video recordings of my treatment may be taken if they may be useful as a component of my treatment.

KH IS NOT RESPONSIBLE FOR MY PERSONAL ITEMS. KH offers temporary safekeeping for essential personal items (i.e. glasses, dentures, hearing aids, or other assistive devices). KH shall not be liable for the loss or damage to any personal item including money or articles of value.

THE FOLLOWING ITEMS AND BEHAVIOR ARE NOT PERMITTED ON KH PROPERTY:

Weapons: I agree to turn over all weapons to Security and I understand that if I am suspected of possessing a weapon, KH has the right to search me and/or my belongings and seize such items.

Illegal Drugs: Substance abuse is prohibited in all areas of KH and I agree to turn over any and all illegal substances. I understand that if I am suspected of possessing an illegal substance or illegal contraband, KH has the right to search me and /or my belongings and seize such items, and I consent to such search and seizure.

Tobacco: KH is a Smoke, Tobacco, and Nicotine Free Facility on all campuses and in all clinics. I understand that I will not be allowed to smoke, utilize an electric simulated smoking device, chew tobacco, or otherwise use these substances during my treatment or service. I understand help and resources are available to me to avoid or reduce tobacco or nicotine withdrawal.

KH MAY GIVE INFORMATION TO MY HEALTH INSURANCE COMPANY FOR PAYMENT. To the extent required to assure payments, KH will disclose any pertinent medical information to a designated representative, corporation, governmental agency or third party payor. Examples of such entities may include insurance companies, workers compensation carriers, the Social Security Administration, or the Department of Health and Human Services. Communication to these entities may include details to support appropriateness of treatment, medical necessity, and financial reimbursement. I understand that disclosures supporting treatment, payment, or operations may extend to, but are not limited to, all aspects of my care, including data related to treatment for HIV/AIDS, sexually transmitted diseases, substance abuse, or mental health conditions, unless expressly limited by me in writing. I understand that limited disclosure may prevent my insurer from paying for my medical care, making me responsible for the cost of my treatment.

IT IS MY RESPONSIBILITY TO PAY MY BILL OR TO MAKE ARRANGEMENTS TO HAVE MY BILL PAID.

Private Pay: As a patient (or a patient's agent), I agree to be financially responsible to KH for charges not paid by my insurance. I understand this amount is due upon receipt of statement. I further understand and agree that as part of the normal business communication with regard to this matter, KH staff or representatives may contact me through any of the following methods: Letter, e-mail, cell phone, text and/or voice messages, or any other available technologies used by businesses for such communication. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for services rendered to the patient. I understand and agree that a delinquent account will be subject to interest at the current legal rate.

Insurance Coverage: I certify that the information provided regarding my insurance policy and eligibility is correct to the best of my knowledge. I hereby authorize KH to receive reimbursement directly from my insurance company. Any portion of charges not paid by the insurance company will be billed to me and is due upon receipt of statement.
I understand that KH will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

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Financial Assistance: As a part of our strong commitment to ensuring access to medical care, KH offers financial assistance for medically necessary services. I understand that I may still qualify for financial assistance even if I have medical insurance. Eligibility is determined based on federal poverty guidelines, family size, and other criteria. I may apply for potential financial assistance prior to service, at the time of service, or at any point in the billing process up to the resolution of the account.

I UNDERSTAND THAT IN ADDITION TO MY KH BILL, I WILL RECEIVE A SEPARATE BILL(S) FROM PHYSICIANS AND/OR CARE PROVIDERS INVOLVED IN MY DIAGNOSIS AND TREATMENT. Because every health insurance plan is different, I understand that KH is unable to ensure that all physicians and/or care providers are preferred providers under my insurance plan, and that I may be responsible for out-of-network rates.

I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT IT IS ALSO AVAILABLE UPON REQUEST. The Notice of Privacy Practices describes how information about me may be used and disclosed and how I can access this information. I have a right to receive a paper copy of this notice, available in all patient registration areas. Kootenai will not use or disclose health information except as indicated in this notice.

I HAVE BEEN OFFERED A COPY OF THE ONLINE PATIENT PORTAL BROCHURE. Your medical information is your information, and the Online Patient Portal provides easy access to review important information at any time.

❑ **Directory Disclosure:** I hereby request that my name not be included in the hospital directory. By invoking this right, I understand that people inquiring by telephone and visitors will be told "I have no information about this patient". No deliveries, including flowers will be forwarded to me.

Agreement: By signing, I am acknowledging that I have received a copy of the patient's rights and responsibilities and by signing, I agree that I understand and accept the terms on this form.

- If the patient is 18 years of age or older, the patient must sign and date the form.
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.

❑ Legal Guardian or Conservator ❑ Health care Agent (Health care power of Attorney)
❑ Other Legal representative Relationship: _____

- **If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: _____**

Signature: _____ Date: _____ Time: _____

Printed Name of person Signing (if not patient): _____

❑ Unable to sign. Reason: _____

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